

HABIT (HELPING ACQUIRED BRAIN INJURY TREATMENT)

APPLICATION FOR FUNDING

Personal Information - SURVIVOR

Last Name: _____ First Name: _____

Address: _____

Date of Birth: _____ Sex: Male Female

Date of Injury: _____

Please explain how the injury occurred: _____

Personal Information - MOTHER

Last Name: _____ First Name: _____

Phone#: _____ Work phone#: _____

Date of Birth: _____

Occupation: _____ Employer: _____

Address: _____

_Email: _____ Dependants #: _____

Gross Monthly Income:	Pension amount:	Social Assistance:	Child Tax Credits:
Other sources of Income:	Other sources of Income:	Insurance Available:	

Please attach most recent tax returns or other proof of above income

Personal Information - FATHER

Last Name: _____ First Name: _____

Phone#: _____ Work phone#: _____

Date of Birth: _____

Occupation: _____ Employer: _____

Address: _____

Email: _____ Dependants#: _____

Gross Monthly Income:	Pension amount:	Social Assistance:	Child Tax Credits:
Other sources of Income:	Other sources of Income:	Insurance Available:	

Please attach most recent tax returns or other proof of above income

Other Assets

Asset	Amount	Asset	Amount
RRSP		Business Interest	
Bank Accounts		House vs. Apartment	
Securities / Bonds		Other property:	
Vehicles including cars, boats and other		Other assets:	

motorized vehicles			
--------------------	--	--	--

EXPENSES

Personal Expenses

Expense type	Amount
Mortgage/Rent	
Loans	
Utilities (gas, hydro, water)	
Television/Telephone	
Credit Cards	
Groceries	
Clothing	
Transportation	
Health & Medical	
Insurance	
Support/Alimony	
Personal Needs	
Child Care Expenses	
Other (specify)	

**Funding Requested
Details:**

Amount/Costing: _____ (attach estimate or receipt)

Recommended by: _____

(attach treatment provider=s recommendation)

I acknowledge that HABIT has clearly identified to me the purposes for which my personal information is being collected and will be used and disclosed by HABIT during the proceedings in connection with this matter. I consent to the collection, use and disclosure of my personal information for the purposes identified by HABIT and acknowledge that my personal information will not be used or disclosed for any other purpose without my prior consent to do so. I also consent to HABIT contacting my health care providers and obtaining and releasing information for the purposes of determining funding and treatment.

I hereby undertake that the information in the proceeding three pages is accurate and completed to the best of my ability.

Signature: _____

Printed Name: _____

Date: _____

When application is considered: further information may be required.

Please submit by fax to 672-8970 or mail to: H.A.B.I.T,
P.O. Box 24136,
London, ON N6A 5C4

or via e-mail: habit@rogers.com

Contact: Lisa Bradshaw
Secretary/Treasurer at 672-4942